SOCIAL WORK IN NEIGHBORHOOD HEALTH CENTERS*

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THE neighborhood health center has done more to bring social work practice in the health field into a modern day format, or at least to make that possible, than any single factor or combination of factors of which I can think. Such centers have taken social work practice in the field of health and elevated it from a position of handmaiden to the physician to that of equal partner in a multidisciplinary rather than an interdisciplinary program.

Much as social workers would like to believe otherwise, their colleagues in hospital settings have played a secondary role to the field of medicine in hospitals. Traditionally their function pure and simple has been to help facilitate the rendering of medical care to the patient, to help the doctor get the patient out of the bed and back into the community as quickly as possible if that is what the doctor has thought necessary, and generally to help the patient to adjust to the system of medical care as established and perpetuated by the medical profession.

In more simple terms, the social worker of the health institutions has never really followed his own bent but has always followed the doctor's recommendation. What the doctors in neighborhood care centers have discovered and what social workers in those centers have hopefully rediscovered is the simple fact that the health system is an important but relatively small part of our total social system, rather than the reverse. This discovery or rediscovery has led in such centers to a reassessment of what really constitutes good care of the patient, with increasing awareness that good medical care and good care of patients are not necessarily synonymous terms.

From its very inception on December 1, 1961, the Gouverneur Health Services Program of the Beth Israel Medical Center, New York—which

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was really the forerunner of the Office of Economic Opportunity whose programs are discussed today—recognized the increasingly important role that social work and social-work theory would have to play in the delivery of good care of patients. The appointment of its first director of Social Service to the position of an administrator was both a real and symbolic demonstration of the importance the behavioral sciences would play in such a program.

The recognition that social, environmental, psychological, familial, educational and employment difficulties all impinged on the health of the patient was quickly recognized, and steps were taken to relieve these pressures with the help of existing social, religious, educational, and cultural organizations in the community. A determination was made quickly that the social-work staff would be responsible for any problem the patient might produce and would have no option to select the types of cases or problems it preferred to handle.

A determination was made immediately that the social worker would enter notes of his contacts with any patient directly into the patient's record, and that such entries would be recorded sequentially. This meant that the worker could no longer take refuge in a separate record far removed from that record which carried the ongoing history of the patient's care.

It was determined that help from social service would be immediately accessible and available to any patient needing such services, and that no patient would be placed on a waiting list for those services. It was determined that the social worker might carry some relatively long-term cases but that he would have to recognize that most patients in low-income areas were concerned with their immediate concrete needs and the relief of stressful problems, not with abstractions.

It was agreed that patients would have direct access to social service without medical referral if the patient saw this as the basis of his need, and it was immediately determined that such patients could continue to come back for such services, irrespective of the type of problem involved. And, most significantly, it was determined that patients would get active, aggressive help in changing the environment where such need was indicated, rather than expecting the patient to accept his environment passively.

All of this was done in the context of a recognition that there could never be sufficient social-work staff to meet the needs of patients in

traditional one-to-one relations. Several years after the inception of the program, Gerald Adelson was appointed the second director of Social Service, and to him must go the greatest portion of the credit for expanding the impact of social service upon the total clinical operation; for implementing a training program that included the case aide and the social service technician; for formalizing the community organization and social-action function of the social service staff; for formalizing ties with professional training schools for strengthening the task-oriented and case-management approach in the delivery of care to the patient; for attracting an innovative staff, and for having the courage and stamina to allow that staff the freedom to serve the patient in accordance with the patient's need rather than with the need of the institution.

In large measure these so-called innovations are actually a throwback to some of the earliest basic principles of social work before the days of its preoccupation with its own professional status and its overconcern with mimicking the medical profession. These principles basically are: a belief in the patient's right to self-determination; a belief in the providing of care or protection to those who could not adequately protect themselves against existing institutions; a belief in equal accessibility to service and treatment for all, irrespective of ability to pay; a belief in the concept of self-help; and, most significantly, a belief in the validity of effecting change through social action and involvement of the consumer.

In social work it seems more and more that the more things change the more they remain the same. Social work has come a full cycle—not to the point of playing the role of Lady Bountiful and not to the point of playing the role of junior psychiatrist—but to the point of believing that the way to help and improve most effectively the health and welfare of the population is by correcting the social ills of our society.